treating physician has reviewed the treatment files, concurred in the action and signed a statement to this effect in the record. Consideration will be given to the veteran's ability to make a rational decision concerning the need for medical care and/or examination. The veteran will be advised of the final decision. Nothing in this section will be construed to prevent treatment for an emergent condition that may arise during or subsequent to this action. Where an appointment is broken without notice and satisfactory reasons are advanced for breaking the appointment and circumstances were such that notice could not be given, the patient will not be deemed to have refused treatment.

(Authority: 38 U.S.C. 7304)

[51 FR 8672, Mar. 13, 1986. Redesignated at 61 FR 21965, May 13, 1996; 64 FR 54218, Oct. 6, 1999]

CHARGES, WAIVERS, AND COLLECTIONS

### § 17.101 Collection or recovery by VA for medical care or services provided or furnished to a veteran for a non-service connected disability.

(a)(1) *General.* This section covers collection or recovery by VA, under 38 U.S.C. 1729, for medical care or services provided or furnished to a veteran:

(i) For a non-service connected disability for which the veteran is entitled to care (or the payment of expenses of care) under a health-plan contract;

(ii) For a non-service connected disability incurred incident to the veteran's employment and covered under a worker's compensation law or plan that provides reimbursement or indemnification for such care and services; or

(iii) For a non-service connected disability incurred as a result of a motor vehicle accident in a State that requires automobile accident reparations insurance.

(2) *Methodology.* Based on the methodology set forth in this section, the charges billed will include, as appropriate, inpatient facility charges, skilled nursing facility/sub-acute inpatient facility charges, outpatient facility charges, physician charges, and non-physician provider charges. In addition, the charges billed for prosthetic devices and durable medical equipment provided on an outpatient basis will be VA's actual cost and the charges billed for prescription drugs not administered during treatment will be a single nationwide average. Data for calculating actual amounts for inpatient facility charges, skilled nursing facility/sub-acute inpatient facility charges, outpatient facility charges, and physician charges will be published annually in the ''Notices'' section of the FEDERAL REGISTER. In those cases in which the effective period for published charges has expired and new charges have not yet become effective, VA will continue to bill using the most recently published charges until new charges are published and become effective (for example, if the most recently published charges state that they are effective through December and new charges are not published and effective until February 1, then the charges set forth for the period through December will continue to be used through January 31).

(3) *Amount of recovery or collection—third party liability.* A third-party payer liable under a health-plan contract has the option of paying either the billed charges described in this section or the amount the health-plan demonstrates is the amount it would pay for care or services furnished by providers other than entities of the United States for the same care or services in the same geographic area. If the amount submitted by the health plan for payment is less than the amount billed, VA will accept the submission as payment, subject to verification at VA's discretion in accordance with this section. A VA employee having responsibility for collection of such charges may request that the third party health plan submit evidence or information to substantiate the appropriateness of the payment amount (e.g., health plan or insurance policies, provider agreements, medical evidence, proof of payment to other providers in the same geographic area for the same care and services VA provided).

(4) *Definitions.* For purposes of this section:

*Consolidated MSA* means a consolidated Metropolitan Statistical Area.

*CPI* means Consumer Price Index.

*CPI–U* means Consumer Price Index—All Urban Consumers.

*CPI–W* means Consumer Price Index—Urban Wage Earners and Clerical Workers .

*CPT procedure code* means a 5 digit-identifier for a specified physician service or procedure.

*DRG* means diagnosis related group.

*Geographic area* means Metropolitan Statistical Area (MSA) or the local market, if the VA facility is not located in an MSA.

*RVU* means relative value unit.

(b) *Inpatient facility charges.* When VA provides or furnishes inpatient services within the scope of care referred to in paragraph (a)(1) of this section, inpatient facility charges billed for such services will be determined in accordance with the provisions of this paragraph. Inpatient facility charges consist of per diem charges for room and board and for ancillary services that vary by VA facility and by DRG. These charges are calculated as follows:

(1) *Formula.* For each inpatient stay or portion thereof for which a particular DRG assignment applies, multiply the nationwide room and board per diem charge as set forth in paragraph (b)(2) of this section by the appropriate geographic area adjustment factor as set forth in paragraph (b)(3) of this section. The result constitutes the facility-specific room and board per diem charge. Also, for each inpatient stay, multiply the nationwide ancillary per diem charge as set forth in paragraph (b)(2) of this section by the appropriate geographic area adjustment factor as set forth in paragraph (b)(3) of this section. The result constitutes the facility-specific ancillary per diem charge. Then add the facility-specific room and board per diem charge to the facility-specific ancillary per diem charge. This constitutes the facility-specific combined per diem facility charge. Finally, multiply the facility-specific combined per diem facility charge by the number of days of inpatient care to obtain the total inpatient facility charge.

NOTE TO PARAGRAPH (b)(1): If there is a change in a patient's condition and/or treatment during a single inpatient stay such that the DRG assignment changes (for example, a psychiatric patient who develops a medical or surgical problem), then the calculations will be made separately for each DRG, according to the number of days of care applicable for each DRG, and the total inpatient facility charge will be the sum of the total inpatient facility charges for the different DRGs.

(2) *Per diem charges.* To establish a baseline, two nationwide average per diem charges for each DRG are calculated for Calendar Year 1995, one from the Medicare Standard Analytical File 5% Sample and one from the MedStat claim database, a claim database of nationwide commercial insurance. Results obtained from these two databases are then combined into a single weighted average per diem charge for each DRG. The resulting weighted average per diem charge for each DRG is then separated into its two components, a room and board component and an ancillary component, with the amount for each component calculated to reflect the corresponding percentage set forth in paragraph (b)(2)(i) of this section. The resulting amounts for room and board and ancillary services for each DRG are then each multiplied by the final ratio set forth in paragraph (b)(2)(ii) of this section to reflect the 80th percentile charges. Finally, the resulting charges are each trended forward from their 1995 base to the effective time period for the charges, as set forth in paragraph (b)(2)(iii) of this section. The results constitute the room and board per diem charge and the ancillary per diem charge.

(i) *Charge component percentages.* Using only those cases from the Medicare Standard Analytical File 5% Sample for which a distinction between room and board charges and ancillary charges can be determined, the percentage of the total charges for room and board compared to the combined total charges for room and board and ancillary services, and the percentage of the total charges for ancillary services compared to the combined total charges for room and board and ancillary services, are calculated by DRG.

(ii) *80th percentile.* Using the medical and surgical admissions in the Medicare Standard Analytical File 5% Sample, obtain for each consolidated MSA the ratio of the day-weighted 80th percentile semi-private room and board per diem charge to the average semi-

private room and board per diem charge. The consolidated MSA ratios are averaged to obtain a final 80th percentile ratio.

(iii) *Trending forward.* For each DRG, the 80th percentile charges, representing calculations for calendar year 1995, are trended forward for the period August 1998 through September 1999, and for each 12-month calendar year period thereafter, beginning January 1, 2000, based on changes to the CPI. The projected total CPI trend from 1995 to the midpoint of the effective charge period is calculated as the composite of three components. The first component trends from 1995 to January 1997, using the Hospital Room component of the CPI–W for room and board charges and using the Other Hospital component of the CPI–W for ancillary charges. The second component trends from January 1997 to the latest available month, based on the Inpatient Hospital component of the CPI–U for room and board and ancillary charges. The third component trends from the latest available month to the midpoint of the effective charge period, based on the latest three-month average annual trend rate from the Inpatient Hospital component of the CPI–U. The projected total CPI trends are then applied to the 1995-base 80th percentile charges.

(3) *Geographic area adjustment factors.* For each VA facility location, the average per diem room and board charges and ancillary charges from the 1995 Medicare Standard Analytical File 5% Sample are calculated for each DRG. The DRGs are separated into two groups, surgical and non-surgical. For each of these groups of DRGs, for each geographic area, average room and board per diem charges and ancillary per diem charges are calculated for 1995, weighted by FY 1997 nationwide VA discharges and by average lengths of stay from the combined Medicare Standard Analytical File 5% Sample and the MedStat claim data base. This results in four average per diem charges for each geographic area: room and board for surgical DRGs, ancillary for surgical DRGs, room and board for non-surgical DRGs, and ancillary for non-surgical DRGs. Four corresponding national average per diem charges are obtained from the 1995 Medicare Standard Analytical File 5% Sample, weighted by FY 1997 nationwide VA discharges and by average lengths of stay from the combined Medicare Standard Analytical File 5% Sample and the MedStat claim data base. Four geographic area adjustment factors are then calculated for each geographic area by dividing each geographic area average per diem charge by the corresponding national average per diem charge.

(c) *Skilled nursing facility/sub-acute inpatient facility charges.* When VA provides or furnishes skilled nursing/sub-acute inpatient services within the scope of care referred to in paragraph (a)(1) of this section, skilled nursing facility/sub-acute inpatient facility charges billed for such services will be determined in accordance with the provisions of this paragraph. The skilled nursing facility/sub-acute inpatient facility charges are per diem charges that vary by VA facility. The facility charges cover care, including skilled rehabilitation services (e.g., physical therapy, occupational therapy, and speech therapy), that is provided in a nursing home or hospital inpatient setting, is provided under a physician's orders, and is performed by or under the general supervision of professional personnel such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech therapists, and audiologists. The skilled nursing facility/sub-acute inpatient facility charges also incorporate charges for ancillary services associated with care provided in these settings. The charges are calculated as follows:

(1) *Formula.* For each stay, multiply the nationwide per diem charge as set forth in paragraph (c)(2) of this section by the appropriate geographic area adjustment factor as set forth in paragraph (c)(3) of this section. The result constitutes the facility-specific per diem charge. Finally, multiply the facility-specific per diem charge by the number of days of care to obtain the total skilled nursing facility/sub-acute inpatient facility charge.

(2) *Per diem charge.* To establish a baseline, a nationwide average per diem billed charge for July 1, 1998, was

obtained from the 1998 Milliman & Robertson, Inc. Health Cost Guidelines, a publication that includes nationwide skilled nursing facility charges (Milliman & Robertson, Inc., 1301 5th Ave., Suite 3800, Seattle, WA 98101–2605). That average per diem billed charge is then multiplied by the 80th percentile adjustment factor set forth in paragraph (c)(2)(i) of this section to obtain a nationwide 80th percentile charge level. Finally, the resulting charge is trended forward to the effective time period for the charges, as set forth in paragraph (c)(2)(ii) of this section.

(i) *80th percentile.* Using the 1995 Medicare Standard Analytical File 5% Sample, the median per diem accommodation charge is calculated for each provider. For each State, the ratio of the 80th percentile of provider median charges to the average statewide charges for accommodations is calculated. The State ratios are averaged to produce a nationwide 80th percentile adjustment factor.

(ii) *Trending forward.* The 80th percentile charge, representing charge levels for July 1, 1998, is trended forward to the midpoint of the period August 1998 through September 1999, and to the midpoint of each 12-month calendar year period thereafter, beginning January 1, 2000, based on the projected change in Medicare reimbursement from the Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund (this report can be found on the Health Care Financing Administration Internet site at *http://www.hcfa.gov* under the headings ''Publications and Forms'' and ''Professional/ Technical Publications'').

(3) *Geographic area adjustment factors.* A ratio of the average per diem charge for each State to the nationwide average per diem charge is obtained (these ratios are set forth in the 1998 Milliman & Robertson, Inc. Health Cost Guidelines, a data base of nationwide commercial insurance charges and relative costs) (Milliman & Robertson, Inc., 1301 5th Ave., Suite 3800, Seattle, WA 98101–2605). The geographic area adjustment factor for charges for each VA facility is the ratio for the State in which the facility is located.

(d) *Outpatient facility charges.* When VA provides or furnishes outpatient services that are within the scope of care referred to in paragraph (a)(1) of this section and are not customarily performed in an independent clinician's office, the outpatient facility charges billed for such services will be determined in accordance with the provisions of this paragraph. Except for prosthetic devices and durable medical equipment, whose charges will be made separately at actual cost to VA, charges for outpatient facility services will vary by VA facility and by CPT procedure code. These charges will be calculated as follows:

(1) *Formula.* For each outpatient facility charge CPT procedure code, multiply the nationwide charge as set forth in paragraph (d)(2) of this section by the appropriate geographic area adjustment factor as set forth in paragraph (d)(4) of this section. The result constitutes the facility-specific outpatient facility charge. When multiple surgical procedures are performed during the same outpatient encounter by a provider or provider team, the outpatient facility charges for such procedures will be reduced as set forth in paragraph (d)(5) of this section.

(2) *Nationwide 80th percentile charges by CPT procedure code.* For each CPT procedure code for which outpatient facility charges apply, the 1998 practice expense RVUs (these RVU's can be found in the *1998 St. Anthony's Complete RBRVS,* Relative Value Studies, Inc., St. Anthony Publishing, 11410 Isaac Newton Square, Reston, VA 20190) are used as the outpatient facility RVUs. For each CPT procedure code, the outpatient facility RVU is multiplied by the charge amount for each incremental RVU as set forth in paragraph (d)(3) of this section. The resulting charge is adjusted by a fixed charge amount as also set forth in paragraph (d)(3) of this section to obtain the nationwide 80th percentile charge.

(3) *Charge factor.* Using the 1995 MedStat claims database of nationwide commercial insurance, the median billed facility charge is calculated for each applicable CPT procedure code. All outpatient facility CPT procedure codes are then separated into one of

the 37 outpatient facility CPT procedure code groups as set forth in paragraph (d)(3)(i) of this section. Then, for each CPT procedure code in each such group, the median charge is adjusted to the 80th percentile as set forth in paragraph (d)(3)(ii) of this section. The resulting 80th percentile charge for each CPT procedure code is trended forward to the effective time period for the charges as set forth in paragraph (d)(3)(iii) of this section. Using the resulting charges and the RVUs, the mathematical approximation methodology of least squares is applied to the data for each CPT procedure code group to derive two charge factors. The first factor represents the charge amount for each incremental RVU in the CPT procedure code group and the second factor represents a fixed charge amount adjustment for the CPT procedure code group.

(i) *Outpatient facility CPT procedure code groups.*

(A) Surgery—Integumentery System—Skin, Subcutaneous & Accessory Structures/Nails;

(B) Surgery—Integumentery System—Repair—Simple, Intermediate, Complex, Adjacent Tissue Transfer or Rearrangement;

(C) Surgery—Integumentery System—Not Otherwise Classified;

(D) Surgery—Musculoskeletal System—Not Otherwise Classified;

(E) Surgery—Musculoskeletal System—Limbs—Incisions/Excisions/Insertion/Removal;

(F) Surgery—Musculoskeletal System—Limbs—Shoulders/Humerus & Elbow/Pelvis & Hip Joint/Femur & Knee Joint—Other than Incisions/Excisions/ Insertion/Removal;

(G) Surgery—Musculoskeletal System—Limbs—Forearm & Wrist—Other than Incisions/Excisions/Insertion/Removal;

(H) Surgery—Musculoskeletal System—Limbs—Tibia/Fibula & Ankle Joint—Other than Incisions/Excisions/ Insertion/Removal;

(I) Surgery—Musculoskeletal System—Limbs—Hand & Fingers/Foot & Toes—Other than Incisions/Excisions/ Insertion/Removal;

(J) Surgery—Musculoskeletal System Arthroscopy;

(K) Surgery—Respiratory System;

(L) Surgery—Cardiovascular System;

(M) Surgery—Hemic & Lymphatic Systems;

(N) Surgery—Digestive System—Not Otherwise Classified;

(O) Surgery—Digestive System—Endoscopy;

(P) Surgery—Urinary System;

(Q) Surgery—Male Genital System;

(R) Surgery—Laparoscopy/Hysteroscopy;

(S) Surgery—Maternity Care & Delivery;

(T) Surgery—Endocrine System;

(U) Surgery—Eye/Ocular Adnexa;

(V) Surgery—Auditory System;

(W) Radiology—Diagnostic—Head & Neck/Chest/Spine & Pelvis;

(X) Radiology—Diagnostic—Extremities/Abdomen/Gastrointestinal Tract/Urinary Tract/Gynecological & Obstetrical/Heart;

(Y) Radiology—Diagnostic—Aorta & Arteries/Veins & Lymphatics;

(Z) Radiology—Diagnostic Ultrasound;

(AA) Radiology—Radiation Oncology/Nuclear Medicine/Therapeutic;

(BB) Radiology—Diagnostic—CAT Scans;

(CC) Radiology—Diagnostic—Magnetic Resonance Imaging (MRI);

(DD) Medicine—Global—Not Otherwise Classified;

(EE) Medicine—Global—Dialysis;

(FF) Medicine—Technical Component—Gastroenterology;

(GG) Medicine—Technical Component—Cardiovascular;

(HH) Medicine—Technical Component—Pulmonary;

(II) Medicine—Technical Component—Neurology & Neuromuscular Procedures;

(JJ) Medicine—Observation Care; and

(KK) Medicine—Emergency.

(ii) *80th percentile.* For each of the 37 outpatient facility CPT procedure code groups set forth in paragraph (d)(3)(i) of this section, the median charge is increased by the ratio of the 80th percentile charge to median charge (the data for CPT procedure code groups listed at paragraphs (d)(3)(i)(DD), (EE), (JJ), and (KK) of this section are obtained from the MedStat database of nationwide charges; the data for the other groups are obtained from the Outpatient Facility UCR module of the

Comprehensive Healthcare Payment System from MediCode, Inc., a 1997 release from a nationwide database of outpatient facility charges) (MediCode, Inc., 5225 Wiley Post Way, Suite 500, Salt Lake, UT 84116). To mitigate the impact of the variation in the intensity of services by CPT procedure code, the percent increase from the median to the 80th percentile in outpatient charges is compared to the percent increase from the median to the 80th percentile in inpatient semi-private room and board charges. Any percent increase in outpatient charges in excess of the inpatient semi-private room and board percent increase is multiplied by a factor of 0.50. The 80th percentile outpatient facility charge is reduced accordingly.

(iii) *Trending forward.* The charges for each CPT procedure code, representing calculations for calendar year 1995, are trended forward for the period August 1998 through September 1999, and for each 12-month calendar year period thereafter, beginning January 1, 2000, based on changes to the Outpatient Hospital component of the CPI–U. Actual CPI–U changes are used through the latest available month. The three-month average annual trend rate as of the latest available month is held constant to the midpoint of the effective charge period. The projected total CPI–U change from 1995 to this midpoint of the effective charge period is then applied to the 1995 80th percentile charges.

(4) *Geographic area adjustment factors.* For each VA outpatient facility location, a single geographic area adjustment factor is calculated as the arithmetic average of the outpatient geographic area adjustment factor (this factor constitutes the ratio of the level of charges for each geographic area to the nationwide level of charges) published in the Milliman & Robertson, Inc. Health Cost Guidelines (Milliman & Robertson, Inc., 1301 5th Ave., Suite 3800, Seattle, WA 98101–2605), and a geographic area adjustment factor developed from the MediCode data. The MediCode-based geographic area adjustment factors are calculated as the ratio of the CPT-weighted average charge level for each VA outpatient facility location to the nationwide CPT-weighted average charge level.

(5) *Multiple surgical procedures.* When multiple surgical procedures are performed during the same outpatient encounter by a provider or provider team as indicated by multiple surgical CPT procedure codes, then the CPT procedure code with the highest facility charge will be billed at 100% of the charges established under this section; the CPT procedure code with the second highest facility charge will be billed at 25% of the charges established under this section; the CPT procedure code with the third highest facility charge will be billed at 15% of the charges established under this section; and no outpatient facility charges will be billed for any additional surgical procedures.

(e) *Physician charges.* When VA provides or furnishes physician services within the scope of care referred to in paragraph (a)(1) of this section, physician charges billed for such services will be determined in accordance with the provisions of this paragraph. Physician charges consist of charges for professional services that vary by VA facility and by CPT procedure code. These charges are calculated as follows:

(1) *Formula.* For each CPT procedure code except those for anesthesia and pathology, multiply the total facility-adjusted RVU as set forth in paragraph (e)(2) of this section by the applicable facility-adjusted conversion factor (facility-adjusted conversion factors are expressed in monetary amounts) set forth in paragraph (e)(3) of this section to obtain the physician charge for each CPT procedure code at a particular VA facility. For each anesthesia and pathology CPT procedure code, multiply the nationwide physician charge as set forth in paragraph (e)(4) of this section by the geographic area adjustment factor as set forth in paragraph (e)(3)(iii) of this section to obtain the physician charge for each anesthesia and pathology CPT procedure code at a particular VA facility.

(2)(i) *Total facility-adjusted RVUs for physician services other than anesthesia, pathology, and specified CPT procedure codes.* The work expense and practice expense components of the RVUs for

CPT procedure codes (other than anesthesia, pathology, and those CPT procedure codes set forth at paragraphs (e)(2)(ii) and (e)(2)(iii) of this section) are compiled (information concerning the RVUs and their components can be obtained from Veterans Health Administration, Office of Finance, Department of Veterans Affairs, 810 Vermont Ave., NW., Washington, DC 20420). For radiology CPT procedure codes, these compilations do not include separately identified technical component RVUs. For CPT procedure codes that generate an outpatient facility charge, the facility practice expense RVU is substituted for the non-facility practice expense RVU (information concerning facility practice expense RVUs can be obtained from Veterans Health Administration, Office of Finance, Department of Veterans Affairs, 810 Vermont Ave., NW., Washington, DC 20420). For Medicine and Surgery CPT procedure codes with separate professional and technical components that also generate an outpatient facility charge, only the professional component is compiled. The sum of the facility-adjusted work expense RVU as set forth in paragraph (e)(2)(i)(A) of this section and the facility-adjusted practice expense RVU as set forth in paragraph (e)(2)(i)(B) of this section equals the total facility-adjusted RVUs.

(A) *Facility-adjusted work expense RVUs.* For each CPT procedure code for each geographic area, the 1998 work expense RVU is multiplied by the 1998 Medicare work adjuster (0.917) and the results are further multiplied by the work expense 1998 Medicare Geographic Practice Cost Index. The result constitutes the facility-adjusted work expense RVU.

(B) *Facility-adjusted practice expense RVUs.* For each CPT procedure code for each geographic area, the 1998 practice expense RVU is multiplied by the practice expense 1998 Medicare Geographic Practice Cost Index. The result constitutes the facility-adjusted practice expense RVU.

(ii) *RVUs for specified CPT procedure codes.* For the following CPT procedure codes, obtain the nationwide 80th percentile billed charges from the nationwide commercial insurance data base compiled by the Health Insurance Association of America (Health Insurance Association of America, 555 13th Street, NW, suite 600E, Washington, DC 20004): 20930, 20936, 22841, 48160, 48550, 54440, 79900, 80050, 80055, 80103, 80500, 80502, 85060, 85095, 85097, 85102, 86077, 86078, 86079, 86485, 86490, 86510, 86580, 86585, 86586, 86850, 86860, 86870, 86890, 86891, 86901, 86910, 86911, 86915, 86920, 86921, 86922, 86927, 86930, 86931, 86932, 86945, 86950, 86965, 86970, 86971, 86972, 86975, 86977, 86978, 86985, 88000, 88005, 88012, 88014, 88016, 88036, 88037, 88104, 88106, 88107, 88108, 88125, 88160, 88161, 88162, 88170, 88171, 88172, 88173, 88180, 88182, 88300, 88302, 88304, 88305, 88307, 88309, 88311, 88312, 88313, 88314, 88318, 88319, 88321, 88323, 88325, 88329, 88331, 88332, 88342, 88346, 88347, 88348, 88349, 88355, 88356, 88358, 88362, 88365, 89100, 89105, 89130, 89132, 89135, 89140, 89141, 89250, 89350, 89360, 92390, 92391, 94642, 94772, 99024, 99071, 99078, 99080, 99082, 99100, 99116, 99135, 99140, 99420, 99450, 99455, 99456. For the following CPT procedure codes, obtain the nationwide 80th percentile billed charges from the Medicare Standard Analytical File 5% Sample: 99070, M0076, M0300. Then divide the nationwide 80th percentile billed charges by the untrended nationwide conversion factor for the corresponding physician CPT procedure code group as set forth in paragraphs (e)(3) and (e)(3)(i). The resulting nationwide total RVUs are multiplied by the geographic adjustment factors as set forth in paragraph (e)(2)(iv) of this section to obtain the facility-specific total RVUs.

(iii) *RVUs for specified CPT procedure codes.* For the following list of CPT procedure codes, the nationwide total RVU is calculated by multiplying the 1998 Medicare work adjuster (0.917) by the work expense RVU and adding the practice expense RVU (the work expense RVU and the practice expense RVU for these CPT procedure codes can be found in the *1998 St. Anthony's Complete RBRVS,* Relative Value Studies, Inc., St. Anthony Publishing, 11410 Isaac Newton Square, Reston, VA 20190): 15824, 15825, 15826, 15828, 15829, 15876, 15877, 15878, 15879, 17380, 21088, 24940, 26587, 32850, 33930, 33940, 36415, 36468, 36469, 41820, 41821, 41850, 41870, 47133, 48554, 50300, 58974, 65760, 65765, 65767, 65771, 69090, 69710, 75556, 76092,

76140, 76350, 78608, 78609, 90700, 90701, 90702, 90703, 90704, 90705, 90706, 90707, 90708, 90709, 90710, 90711, 90712, 90713, 90714, 90716, 90717, 90718, 90179, 90720, 90721, 90724, 90725, 90726, 90727, 90728, 90730, 90732, 90733, 90735, 90737, 90741, 90742, 90744, 90745, 90746, 90747, 90882, 90889, 90989, 90993, 92531, 92532, 92533, 92534, 92551, 92559, 92560, 92590, 92591, 92592, 92593, 92594, 92595, 92992, 92993, 93760, 93762, 93784, 93786, 93788, 93790, 95120, 95125, 95130, 95131, 95132, 95133, 95134, 96110, 96545, 97545, 97546, 99000, 99001, 99002, 99025, 99050, 99052, 99054, 99056, 99058, 99075, 99090, 99190, 99191, 99192, 99288, 99358, 99359, 99360, 99361, 99362, 99371, 99372, 99373. The resulting nationwide total RVUs are multiplied by the geographic adjustment factors as set forth in paragraph (e)(2)(iv) of this section to obtain the facility-specific total RVUs.

(iv) *RVU geographic area adjustment factors for specified CPT procedure codes.* The geographic area adjustment factor for each facility location consists of the weighted average of the 1998 work expense and practice expense Medicare Geographic Practice Cost Indices for each facility location using charge data for representative CPT procedure codes statistically selected and weighted for work expense and practice expense.

(3) *Facility-adjusted 80th percentile conversion factors.* CPT procedure codes are separated into the following 24 physician CPT procedure code groups: allergy immunotherapy, allergy testing, anesthesia, cardiovascular, chiropractor, consults, emergency room visits and observation care, hearing/speech exams, immunizations, inpatient visits, maternity/cesarean deliveries, maternity/non-deliveries, maternity/normal deliveries, miscellaneous medical, office/home urgent care visits, outpatient psychiatry/alcohol and drug abuse, pathology, physical exams, physical medicine, radiology, surgery, therapeutic injections, vision exams, and well baby exams. For each of the 24 physician CPT procedure code groups, representative CPT procedure codes were statistically selected and weighted so as to give a weighted average RVU comparable to the weighted average RVU of the entire physician CPT procedure code group (the selected CPT procedure codes are set forth in the 1998 Milliman & Robertson, Inc., Health Cost Guidelines fee survey) (Milliman & Robertson, Inc., 1301 5th Ave., suite 3800, Seattle, WA 98101–2605). The 80th percentile charge for each selected CPT procedure code is obtained (this is contained in the nationwide commercial insurance data base compiled by the Health Insurance Association of America, 555 13th Street NW., Suite 600E, Washington, DC 20004 (medical data for 5/1/96–4/30/97, including radiology and pathology; surgical data for 3/1/96–2/28/97; anesthesia data for 3/1/96–2/28/97)). A nationwide conversion factor (a monetary amount) is calculated for each physician CPT procedure code group as set forth in paragraph (e)(3)(i) of this section. The nationwide conversion factors for each of the 24 physician CPT procedure code groups are trended forward as set forth in paragraph (e)(3)(ii) of this section. The resulting amounts for each of the 24 groups are multiplied by geographic area adjustment factors as set forth in paragraph (e)(3)(iii) of this section, resulting in facility-adjusted 80th percentile conversion factors for each VA facility geographic area for the 24 physician CPT procedure code groups for the effective charge period.

(i) *Nationwide conversion factors.* Using the nationwide 80th percentile charges for the selected CPT procedure codes from paragraph (e)(3) of this section, a nationwide conversion factor is calculated for each of the 24 physician CPT procedure code groups by dividing the weighted average charge by the weighted average RVU. To correspond with the charge data, for medicine and surgery CPT procedure codes, the total RVUs are used even when separate professional and technical components are specified.

(ii) *Trending forward.* The nationwide conversion factor for each of the 24 physician CPT procedure code groups, representing charges for time periods detailed in paragraph (e)(3) of this section, are trended forward for the period August 1998 through September 1999, and for each 12-month calendar year period thereafter, beginning January 1, 2000, based on changes to the Physician component of the CPI–U. Actual CPI–U changes are used through the latest

available month. The three-month average annual trend rate as of the latest available month is held constant to the midpoint of the effective charge period. The projected total CPI–U change from the midpoint of the source data collection period to the midpoint of the effective charge period is then applied to the 24 conversion factors.

(iii) *Geographic area adjustment factors.* Using the 80th percentile charges for the selected CPT procedure codes from paragraph (e)(3) of this section for each VA facility geographic area, a geographic area-specific conversion factor is calculated for each of the 24 physician CPT procedure code groups by dividing the weighted average charge by the weighted average facility-adjusted RVU. The resulting geographic area conversion factor for each facility geographic area for each physician CPT procedure code group is divided by the corresponding nationwide conversion factor as set forth in paragraph (e)(3)(i). The resulting ratios are the geographic area adjustment factors for each of the 24 physician CPT procedure code groups for each facility geographic area.

(4) *Nationwide 80th percentile charges for anesthesia and pathology CPT procedure codes.* The nationwide charges are calculated by multiplying the RVUs as set forth in paragraph (e)(4)(i) of this section for anesthesia CPT procedure codes and as set forth in paragraph (e)(4)(ii) of this section for pathology CPT procedure codes by the appropriate nationwide trended 80th percentile conversion factors as set forth in paragraph (e)(3) of this section.

(i) *RVUs for anesthesia.* The 1998 base unit value for each anesthesia CPT procedure code is compiled (the base unit values can be found in the *1998 St. Anthony's Complete RBRVS,* Relative Value Studies, Inc., St. Anthony Publishing, 11410 Isaac Newton Square, Reston, VA 20190). The average time unit value for each anesthesia CPT procedure code is compiled from a Health Care Financing Administration study concerning average time unit values for anesthesia CPT procedure codes (these values can be obtained from Veterans Health Administration, Office of Finance, Department of Veterans Affairs, 810 Vermont Ave., NW., Washington, DC 20420). For each anesthesia CPT procedure code introduced since the Health Care Financing Administration study, the time unit value is calculated as the average time unit value for all other anesthesia CPT procedure codes with the same base unit value. The sum of the anesthesia base unit value and the anesthesia time unit value equals the total anesthesia RVUs.

(ii) *RVUs for pathology.* For each pathology CPT procedure code, the 1998 Medicare payment amount is used as the RVU for the corresponding CPT procedure code (the payment amounts can be found on the Health Care Financing Administration public use files Internet site at *http://www.hcfa.gov/stats/pufiles.htm* under the heading ''Payment Rates/ Non-Institutional Providers'' and the title ''Clinical Diagnostic Laboratory Fee Schedule.''

(f) *Other provider charges.* When the following providers provide or furnish VA care within the scope of care referred to in paragraph (a)(1) of this section, charges for that care covered by a CPT procedure code will be determined based on the following indicated percentages of the amount that would be charged if the care had been provided by a physician under paragraph (e) of this section:

(1) Nurse practitioner: 85%.

(2) Clinical nurse specialist: 85%.

(3) Physician Assistant: 85%.

(4) Certified registered nurse anesthetist: 50% when physician supervised; 100% when not physician supervised.

(5) Clinical psychologist: 80%.

(6) Clinical social worker: 75%.

(7) Podiatrist: 100%.

(8) Chiropractor: 100%.

(9) Dietitian: 75%.

(10) Clinical pharmacist: 80%.

(11) Optometrist: 100%.

(g) *Outpatient dental care and prescription drugs not administered during treatment.* Notwithstanding other provisions of this section, when VA provides or furnishes outpatient dental care or prescription drugs not administered during treatment, within the scope of care referred to in paragraph (a)(1) of this section, charges billed separately for such care will be based on VA costs in

accordance with the methodology set forth in §17.102 of this part.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0606.)

(Authority: 38 U.S.C. 101, 501, 1701, 1705, 1710, 1721, 1722, 1729)

[64 FR 22678, Apr. 27, 1999]

### §17.102 Charges for care or services.

Except as provided in §17.101, charges at the indicated rates shall be made for Department of Veterans Affairs hospital care or medical services (including, but not limited to, dental services, supplies, medicines, orthopedic and prosthetic appliances, and domiciliary or nursing home care) as follows:

(a) *Furnished in error or on tentative eligibility.* Charges at rates prescribed by the Under Secretary for Health shall be made for inpatient or outpatient care or services (including domiciliary care) authorized for any person on the basis of eligibility as a veteran or a tentative eligibility determination under §17.34 but he or she was subsequently found to have been ineligible for such care or services as a veteran because the military service or any other eligibility requirement was not met, or

(b) *Furnished in a medical emergency.* Charges at rates prescribed by the Under Secretary for Health shall be made for any inpatient or outpatient care or services rendered any person in a medical emergency who was not eligible for such care or services as a veteran, if:

(1) The care or services were rendered as a humanitarian service, under §17.43(c)(1) or §17.95 to a person neither claiming eligibility as a veteran nor for whom the establishment of eligibility as a veteran was expected, or

(2) The person for whom care or services were rendered was a Department of Veterans Affairs employee or a member of a Department of Veterans Affairs employee's family; or

(c) *Furnished beneficiaries of the Department of Defense or other Federal agencies.* Except as provided for in paragraph (f) of this section and the second sentence of this paragraph, charges at rates prescribed by the Office of Management and Budget shall be made for any inpatient or outpatient care or services authorized for a member of the Armed Forces on active duty or for any beneficiary or designee of any other Federal agency. Charges for services provided a member or former member of a uniformed service who is entitled to retired or retainer pay, or equivalent pay, will be at rates prescribed by the Secretary (E.O. 11609, dated July 22, 1971, 36 FR 13747), or

(d) *Furnished pensioners of allied nations.* Charges at rates prescribed by the Under Secretary for Health shall be made for any inpatient or outpatient care or services rendered a pensioner of a nation allied with the United States in World War I and World War II; or

(e) *Furnished under sharing agreements.* Charges at rates agreed upon in an agreement for sharing specialized medical resources shall be made for all medical care or services, either on an inpatient or outpatient basis, rendered to a person designated by the other party to the agreement as a patient to be benefited under the agreement; or

(f) *Furnished military retirees with chronic disability.* Charges for subsistence at rates prescribed by the Under Secretary for Health shall be made for the period during which hospital care is rendered when such care is rendered to a member or former member of the Armed Forces required to pay the subsistence rate under §17.47 (b)(2) and (c)(2).

(g) *Furnished for research purposes.* Charges will not be made for medical services, including transportation, furnished as part of an approved Department of Veterans Affairs research project, except that if the services are furnished to a person who is not eligible for the services as a veteran, the medical care appropriation shall be reimbursed from the research appropriation at the same rates used for billings under paragraph (b) of this section.

(h) *Computation of charges.* The method for computing the charges under paragraphs (a), (b), (d), (f), and (g) and the last sentence of paragraph (c) of this section is based on the Cost Distribution Report, which sets forth the actual basic costs and per diem rates